4 DUAL ELIGIBLES

Medicare beneficiaries who also qualify for Medicaid benefits through their states are referred to as "dual eligibles." Dual eligibles receive Medicaid benefits because they are either categorically eligible or medically needy. The categorically eligible meet an income and asset standard, while the medically needy meet a separate state income standard and are also aged, disabled, or a member of a family with dependent children (PPRC, 1997). There are generally three distinct categories of dual eligibles: Medicare beneficiaries who receive a full range of Medicaid benefits, Qualified Medicare Beneficiaries (QMBs), and Specified Low-Income Medicare Beneficiaries (SLMBs).

Dual Eligibles Receiving Full Medicaid Benefits

The first group receives the full range of Medicaid coverage, typically because they are also eligible for Supplemental Security Income (SSI) or spend down income to Medicaid eligibility. Medicaid is responsible for their Medicare premiums, deductibles, and copayments. Medicaid also pays for additional services not covered by Medicare. "Such services vary by state, but often include prescription drug coverage; nursing home and other institutional care; home care; dental care; mental health care and other therapy; eye care; and transportation to and from providers (PPRC, 1997)." Alternatively, dual eligibles may qualify for Medicaid as QMBs or SLMBs.

Qualified Medicare Beneficiaries

Congress enacted the QMB program in 1988, since the Medicare program's cost-sharing provisions—premiums, deductibles, and copayments—can present a formidable financial burden for low-income or financially indigent beneficiaries. A QMB is defined as a Medicare beneficiary whose income does not exceed 100 percent of the Federal poverty level (FPL)[1] and whose resources do not exceed twice the amount established for SSI eligibility.[2] The QMB program requires State Medicaid programs to pay Medicare cost-sharing amounts, including Part B premiums and Part A and B deductibles and copayments, for low-income Medicare beneficiaries who are not qualified for SSI. Some of these beneficiaries receive full Medicaid benefits, but most QMBs live in states where Medicaid does not pay for services that are not covered by Medicare. QMBs are generally counted as dual eligibles.

Specified Low-Income Medicare Beneficiaries

For elderly and disabled people with incomes between 100 and 120 percent of the FPL, the Federal government has mandated that State Medicaid programs cover their Medicare Part B premiums but not any other Medicare cost-sharing. Since SLMBs do not receive other benefits from State Medicaid programs, they are often excluded from studies of the dual eligible population.

Participation rates for the QMB and SLMB programs remain low, although estimates are not consistent across studies (Barents Group, 1999; Rosenbach and Lamphere, 1999; Neumann et al., 1995; Moon et al., 1996; Weissman and Epstein, 1994). Studies show that a large proportion of low-income Medicare beneficiaries who are qualified for the QMB and SLMB programs are not receiving the benefits, because they have not been identified or enrolled in the programs. In 1995, about 41 percent of QMB eligibles and 15 percent of SLMB eligibles were enrolled in the two programs (Neumann et al., 1995; Rowland and Lyons, 1998).

This chapter focuses on issues related to dual eligibles and QMBs residing in the community.[3] The chapter highlights policy issues concerning health care service delivery to this population. It also examines the population's demographic profile, access to care, service utilization patterns, and issues related to their personal health care expenditures. Since the MCBS data did not differentiate between dual eligibles and QMBs until 1995, comparisons to earlier years cannot be made.

[1] In 1995, the FPL was $7,309 for individuals and $9,219 for married couples 65 or over.

[2] In 1995, the SSI asset threshold was $4,000 for single individuals and $6,000 for married couples. The value of home and household goods is disregarded in determining QMB or SLMB eligibility.

[3] Hereafter referred to as "dual eligibles" or the "dual population."

Medicaid Coverage for Dual Eligibles

The joint Federal-state program is state-operated under broad Federal standards.[4] There are no uniform national regulations for State Medicaid programs concerning eligibility policies, scope of benefits, utilization limits, reimbursement rates for benefits, or provider payment policies. Therefore, the proportion of Medicare beneficiaries who are enrolled in Medicaid and payments made on their behalf can vary considerably from state to state.

While enjoying full Medicare benefits, dual eligibles also receive an array of additional benefits from Medicaid. Categorically eligible and medically needy beneficiaries, in almost all states, are eligible for services that Medicare does not cover. Mandatory Medicaid-covered services include hospital and physicians' services, laboratory and X-ray services, nursing home, and home health care. States have broad discretion, however, in defining coverage for both mandatory and optional services. In addition to the mandatory services, states may elect to cover other services such as prescription drugs, dental care, clinic services, eye care, and hearing aids. States may impose time or frequency limits on coverage, such as ceilings on inpatient days or physician visits. In 1993, 49 states limited physicians' services to categorically needy beneficiaries in some way (HCFA, 1993). They established utilization controls such as medical necessity reviews, prior authorization for certain services, and second surgical opinion programs. Some states also have instituted beneficiary cost sharing as a form of utilization control.[5] These cost sharing responsibilities vary greatly from state to state. However, Federal law stipulates that providers may not deny services if a beneficiary cannot pay the cost-sharing amount (PPRC, 1996).

Cost Issues for Dual Eligibles

Skyrocketing Medicare and Medicaid costs, both increasing at more than 10 percent a year for the past decade, have caused concern at both the Federal and state levels of government. Dual eligibles contribute to the rising costs, because this population tends to be sicker than other groups of Medicare beneficiaries and it uses a disproportionately large share of health care services. Moreover, the structure of the payment system, with Medicare, overseen by the Federal Government, and Medicaid, administered by states, each paying for a different part of health care for the dual eligibles, aggravates the cost problem. One problem is that incentives for cost-efficient patient management often are not aligned with organizations' fiscal interest. "Any savings that a Medicaid program is able to achieve in acute care costs accrue largely to Medicare, since the principal Medicaid costs for such individuals are relatively constant, regardless of the level of utilization. On the other hand, if a nursing home patient must be hospitalized, Medicare picks up virtually the entire bill (National Health Policy Forum, 1995)."

Another problem is that cost-shifting often happens in both directions to satisfy revenue needs (National Health Policy Forum, 1997; Mitchell, 1997; Clark and Hulbert, 1998). Patients sometimes are placed to preserve providers' financial viability rather than to deliver the most cost-efficient services that are appropriate for patients. These incentives result in preventable admissions to hospitals, skilled nursing facilities, and long-term nursing home facilities. In addition, beneficiaries sometimes are prescribed expensive services even though less expensive substitutes are available. States would prefer to use as much Medicare home health care as possible, for instance, even when less expensive Medicaid services such as homemaker services are appropriate (Mitchell, 1997). Consequently, there are higher costs to both Medicare and Medicaid.

Adequacy of Care—Coordination and Quality

Another consequence of the bifurcated payment systems is that health services for dual eligibles are fragmented. There is currently little coordination between Medicare, which is largely responsible for acute and primary care, and Medicaid programs, which provide

[4] Overall, Federal funds accounted for about 57 percent of total Medicaid spending in 1995.

[5] Federal statute constrains the use of this strategy, however, to nominal copayments only (e.g., $1 per physician visit) and to certain groups of beneficiaries.

long-term care and other wrap-around services (Clark and Hulbert, 1998). Since there is no accountability, providers often do not develop a comprehensive care package for the patient. Rather, responsibility for care outcome is passed from one provider to another. "The result … is an inefficient, administratively-treacherous, and non-customer-focused delivery system for disabled persons and elderly persons (Faulkner & Gray, 1996)."

The fragmentation of financing, case management, and service for dual eligibles has prompted several initiatives to integrate Medicare and Medicaid services through managed health care plans. These initiatives are intended to improve the quality and reduce the cost of care provided to dual eligibles. Examples of the initiatives include the Robert Wood Johnson Foundation's Medicare/ Medicaid Integration Program (MMIP), the Minnesota Model,[6] and waiver requests from a consortium of New England States that would enable them to create an integrated Medicaid-Medicare plan so as to streamline delivery of Medicare and Medicaid benefits to dual eligibles.

Characteristics Of the Dual Population

Estimates of dual eligibles and QMBs are not consistent, primarily because of limitations with the Medicaid data (National Health Policy Forum, 1997; Merrel et al., 1997; Rowland and Lyons, 1998; Rosenbach and Lamphere, 1999). The 1997 annual report by the Physician Payment Review Commission stated that data and information on the dual population are "limited by variations among states in the breadth and scope of their Medicaid programs as well as inaccuracies in state reporting (PPRC, 1997)." As a result, estimates of dual eligibles range from 4 million to 6 million persons in 1995. The MCBS data indicate that, in 1995, approximately 2.5 million beneficiaries (6.5 percent) were dual eligibles, and another 3 million (7.9 percent) were QMBs.[7]

Although dual eligibles receiving full Medicaid benefits and QMBs have similar characteristics, they differ significantly from the nondual Medicare population in almost all major socio-demographic and health indicators. The dual population exhibits many characteristics that are either direct indicators or correlates of low socioeconomic status, and high morbidity and mortality rates (National Health Policy Forum, 1997; Merrel et al., 1997; Experton, 1997; PPRC, 1997; Rowland and Lyons, 1998).

Table 4-1 shows the distribution of dual eligibles and other Medicare beneficiaries by selected characteristic. The dual population is over-represented by beneficiaries age 85 and over (17 percent vs. 9 percent) and under age 65 (30 percent vs. 8 percent), by females (66 percent vs. 55 percent), and by racial and ethnic minorities (40 percent vs. 12 percent). An overwhelming majority of them did not finish high school, 72 percent versus 36 percent, which helps to explain why this group is more likely to have low income. In addition to Medicaid coverage, around 9 percent of them have private health insurance; whereas for the nondual population, 73 percent of them have private supplemental health insurance.

The health status of the dual population corresponds to its socioeconomic status. Dual eligibles are twice as likely as nonduals to report that they are in fair or poor health (49 percent vs. 25 percent), and 4 times as likely to be diagnosed as having a mental disorder (24 percent vs. 6 percent). Forty-six percent of them reported that they have at least one limitation in activities of daily living, compared to 21 percent fo the nonduals. Approximately 27 percent of them were institutionalized during 1995, which is more than 4 times the rate of institutionalization in the nondual population. However, a large proportion of nursing home residents did not start their stays as dual eligibles. Rather, they became eligible for Medicaid after facility stay costs depleted their assets.

[6] Minnesota's project, a model program called Senior Health Options, creates a single entity that will be accountable to both the state and the Federal Government for providing a comprehensive health care benefits package.

[7] Medicaid eligibility, in the MCBS, can be determined from HCFA's administrative data or the sample person's self-reported insurance coverage, but the two sources do not always agree. Since HCFA's data allow us to distinguish between full-benefit dual eligibles and QMBs, we use this source to analyze the dual population's characteristics, utilization patterns, and access problems. However, researchers have pointed out that the administrative data may undercount QMBs and those who receive full Medicaid benefits (Rosenbach and Lamphere, 1999). Therefore, we use both HCFA's administrative data and sample person's response to health insurance questions to compare personal health care expenditures by insurance status.

Table 4-1. Characteristics of Dual Eligibles and Other Medicare Beneficiaries, 1995

Characteristic	Dual Eligibles (2.5 million)	QMBs (3.0 million)	Other Beneficiaries (32.5 million)
Percentage of Medicare Population	6.5	7.9	85.6
	Beneficiaries as a Percentage of Column Total[1]		
Female	63.8	69.1	55.2
Age			
Under 65 years	30.7	29.7	8.0
65 - 74 years	28.9	29.4	52.5
75 - 84 years	22.6	24.3	30.2
85 years and older	17.7	16.5	9.4
Race/Ethnicity			
White non-Hispanic	60.0	59.7	87.7
Black non-Hispanic	24.0	21.6	6.7
Other	15.2	18.2	5.5
Education Levels			
0-11 years	73.2	71.5	36.2
12 years	17.0	21.1	34.2
13 or more years	9.8	7.4	29.6
Metropolitan Area Resident	61.1	71.7	74.5
Private Insurance	10.1	7.5	72.8
At Least One Month of Medicare HMO Enrollment	3.4	4.1	11.7
Institutionalized	27.9	26.5	6.1
Fair or Poor Health	49.0	49.5	25.1
Mental Disorder	23.8	23.2	5.7
Functional Limitation			
IADL only[2]	27.8	24.7	19.7
One to two ADLs[3]	22.0	20.0	12.2
Three to five ADLs	23.9	26.6	9.1

1 Percentages do not always add up to 100, because of missing data and omitted categories.

2 *IADL* stands for Instrumental Activity of Daily Living.

3 *ADL* stands for Activity of Daily Living.

Health Care Expenditures by the Dual Population

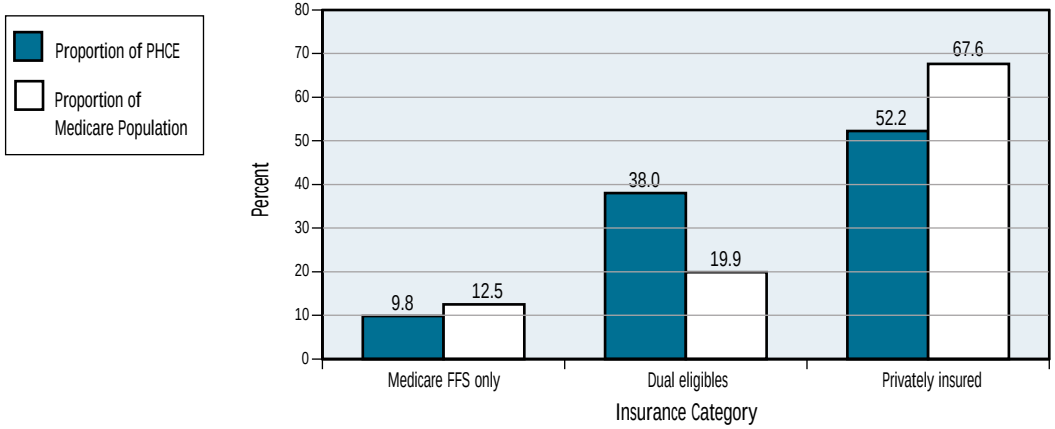
The dual population incurs a disproportionately large share of health care expenditures compared to other Medicare beneficiaries (National Health Policy Forum, 1997; Experton, 1997; Clark and Hulbert, 1998).[8] In 1995, the dual population spent $118 billion on health care, while the rest of the Medicare population spent $192 billion. Figure 4-1a shows the distribution of Medicare beneficiaries by insurance status and share of expenditures on personal health care.[9] The dual population accounted for 38 percent of total expenditures by Medicare beneficiaries even though it constituted no more than 20 percent of the population. Per capita spending by the dual population was more than double that of other beneficiaries, an average of $17,000 per person compared to $6,900 for the nonduals.

Per capita expenditures on health care by the dual population are inflated because almost one-third of them were part or full year nursing home residents (Saucier et.al., 1998). Expenditures of the dual and nondual populations can be made more comparable by eliminating nursing home care from the comparisons. Figure 4-1b presents the same distributions as Figure 4-1a, but excludes all nursing home residents from the analysis. The proportion of expenditures by the dual population still exceeds its representation in the Medicare population (20 percent vs. 16

8 Since dual eligibles receiving full Medicaid benefits and QMBs have similar demographic and health characteristics, the discussion of expenditures, financing, and utilization of health care is for the combined groups.

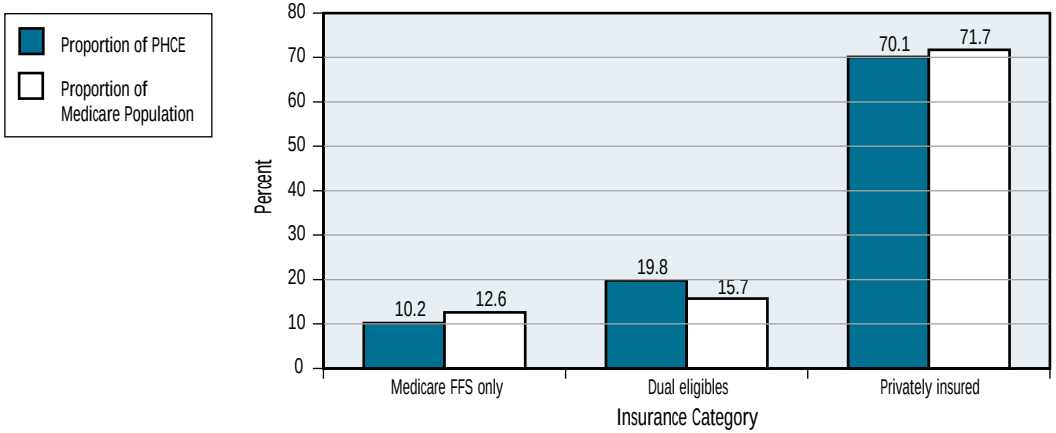
9 The proportion of the dual population reported here is based on the sample person's responses to questions about health insurance coverage as well as on HCFA's administrative data.

Figure 4-1a Distribution of Personal Health Care Expenditures, by Health Insurance Category, 1995



percent), but the contrast between the dual and nondual population is no longer as sharp. Per capita spending by dual eligibles ($7,838) was only 29 percent higher than beneficiaries with private insurance ($6,081), and 56 percent higher than beneficiaries with Medicare fee-for-service-only ($5,011). These differences can largely be explained by the fact that the dual population has more health care demands (Liu, Long, and Aragon, 1998) and more comprehensive insurance coverage than most other beneficiaries (Parente and Evans, 1998).

Figure 4-1b Distribution of Personal Health Care Expenditures of Community-Only Medicare Beneficiaries, by Health Insurance Category, 1995



Financing of Health Care

Dual eligibles rely heavily on public resources, such as Medicare and Medicaid, for their health care needs. Figure 4-2a shows that nearly 80 percent of personal health care expenditures by the dual population was paid by Medicare (44 percent) and Medicaid (35 percent) in 1995. Medicare pays the larger amount because Medicaid is a payer of last resort. "In practice, this means that Medicare pays for all services in its benefits package and that Medicaid acts much like a supplemental insurance policy, paying for the Medicare deductible, coinsurance, and any services in the state's Medicaid benefits package that Medicare does not cover" (PPRC, 1997). Even though Medicare's share of payments for dual eligibles is smaller than that for their counterparts with Medicare fee-for-service-only (49 percent) or private insurance (61 percent), average Medicare payment for a person with dual eligibility ($7,500) was almost double that of a nondual beneficiary ($4,000). Total Medicare payment for the dual population amounted to $52 billion in 1995. Medicare is the predominant public resource for dual eligibles' health care needs if spending on nursing home care is excluded from the comparisons. Figure 4-2b shows source of payment data for community-only residents. When full- and part-year nursing home residents are excluded from the analysis, Medicare and Medicaid's joint contribution for the dual population rises to 88 percent of their total personal health care expenditures. Medicare pays the most (74 percent), with an average Medicare payment of $5,800 for a dually eligible community resident, and $3,800 for a nondual community resident.

Figure 4-2a Sources of Payment for All Medicare Beneficiaries, by Health Insurance Category, 1995

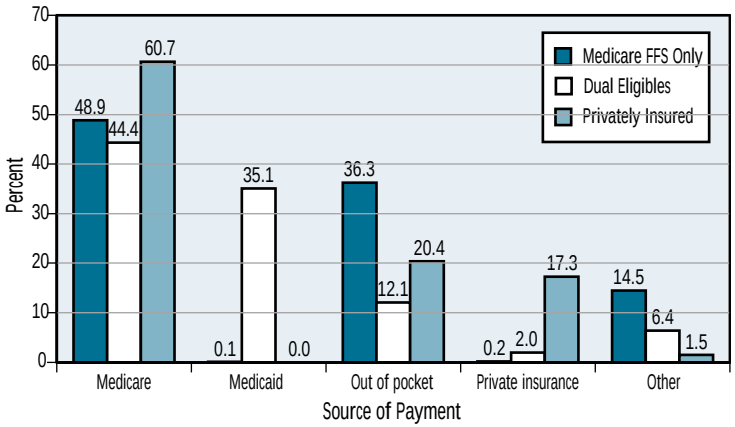
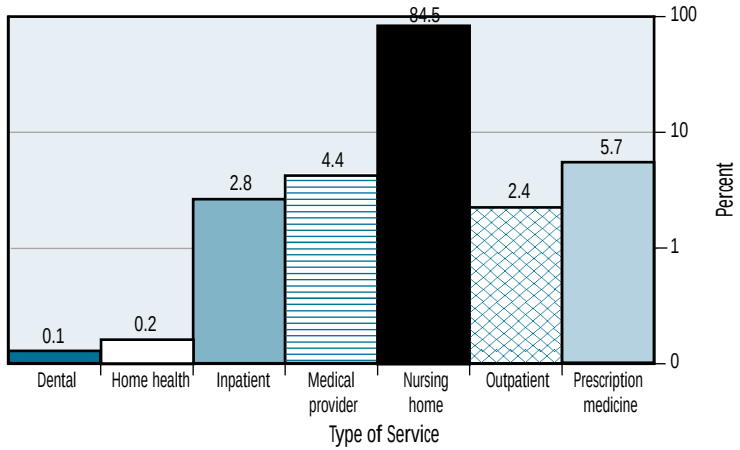
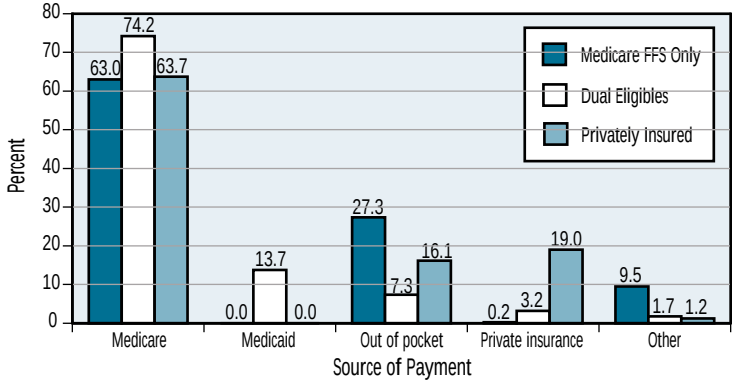


Figure 4-3 Medicaid Share of Payments for Dual Eligibles by Service Type, 1995



Since nursing home care is by far the most expensive type of health care and Medicare does not cover long-term custodial care, Medicaid, even acting in a supplemental role, spends more than one-third of its revenues on the dual population (National Health Policy Forum, 1997). In 1995, total Medicaid reimbursement for dual eligibles was $41 billion, and the per capita Medicaid payment was $5,913. Figure 4-3 illustrates where the Medicaid payments go for the dual population. Most of the spending was on nursing home care (85 percent), with some spending on prescription medicines (6 percent), medical provider services (4 percent), and inpatient hospital services (3 percent).

Figure 4-2b Sources of Payment for Community-Only Residents, by Health Insurance Category, 1995



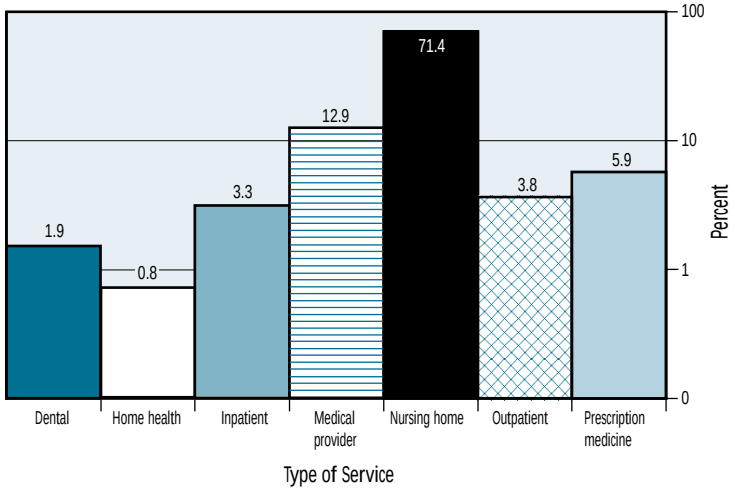
Contrary to the "first-dollar coverage" myth, most dual eligibles have considerable cost-sharing responsibilities, with per capita out-of-pocket (OOP) payments reaching to thousands of dollars. In 1995, for example, per capita OOP payments for dual eligibles were $2,047, compared with $1,570 for the nonduals. The amount of OOP payment varies considerably by state and Census division, largely due to variation in the breadth and scope of Medicaid coverage and other geographic differences. Table 4-2 shows the average OOP payment by Census division. The top three Census divisions, i.e., West North Central, Pacific, and Mountain, have much higher average OOP payments than the average for dual eligibles in general.

Table 4-2. Per Capita Out-of-Pocket Payments by Dual Eligibles, by Census Division, 1995

Census Division	Dual Eligibles	
	Number (000's)	Per Capita OOP
New England	58	$140
Middle Atlantic	341	$1,753
East North Central	361	$1,716
West North Central	104	$3,076
South Atlantic	602	$1,622
East South Central	235	$518
West South Central	328	$224
Mountain	133	$2,595
Pacific	306	$2,838

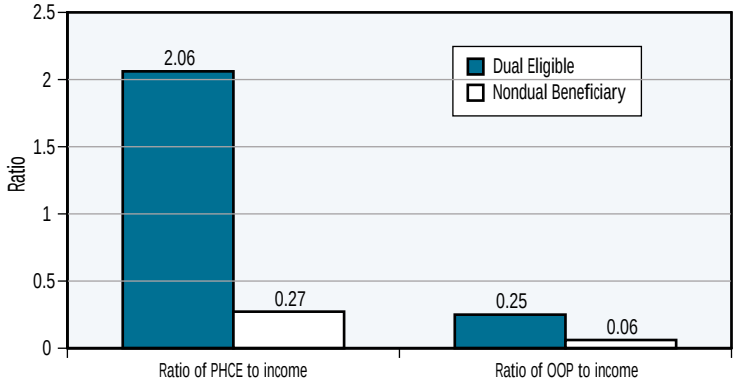
Figure 4-4 shows the distribution of OOP spending on health care services by dual eligibles in 1995. Even though Medicaid provides substantial coverage of nursing home costs, dual eligibles must contribute to their nursing home care as long as they have income. They also may have to pay the full cost of services provided in personal care homes and other places that are not certified by Medicaid (Feinleib and Cunningham, 1994).[10] In 1995, dual eligibles spent 71 percent of their OOP payment on nursing home care, 13 percent on medical provider services, 6 percent on prescription medicines, and 4 percent on outpatient services.

Figure 4-4 Out-of-Pocket Payments by Dual Eligibles, by Service Type, 1995



Out-of-pocket spending on health care can be a heavy burden on the dual population. Figure 4-5a reveals that in 1995, the ratio of average personal health care expenditures to income was 2.1 for dual eligibles ($16,851:$8,180), compared with a ratio of 0.3 for the nonduals ($6,844: $25,103). Even with Medicare and Medicaid coverage, the average out-of-pocket expense for dual eligibles ($2,047) still represents 25 percent of their income versus 6 percent for the nonduals. Moreover, these figures do not show the extent to which OOP payments for health care are driven by the cost of long-term care. The effect of nursing home residency on OOP payments is shown in Figure 4-5b, which presents the ratio of OOP payments to income for beneficiaries by Medicaid and residency status. Not surprisingly, the nonduals who are part or full year nursing home residents have the highest ratio of OOP expense to income (0.69 and 1.15, respectively), since most of them pay all their nursing

Figure 4-5a Ratio of Personal Health Care Expenditures and Out-of-Pocket Payments to Income by Medicaid Status, 1995



[10] Part of the OOP expense could also be incurred during the months they were not yet eligible for Medicaid.

Figure 4-5b Ratio of Out-of-Pocket Payments to Income, by Medicaid and Residency Status, 1995

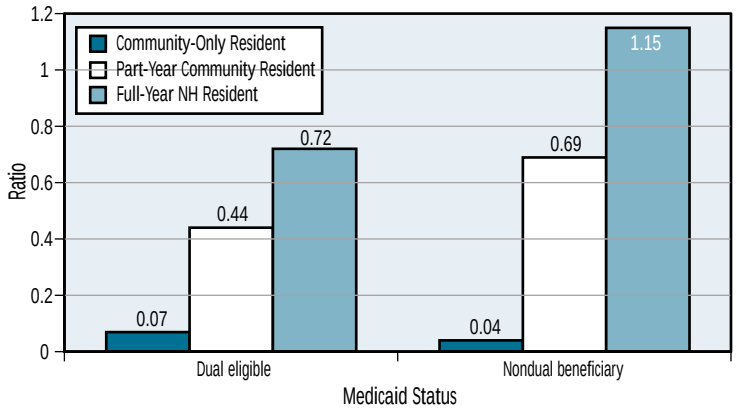
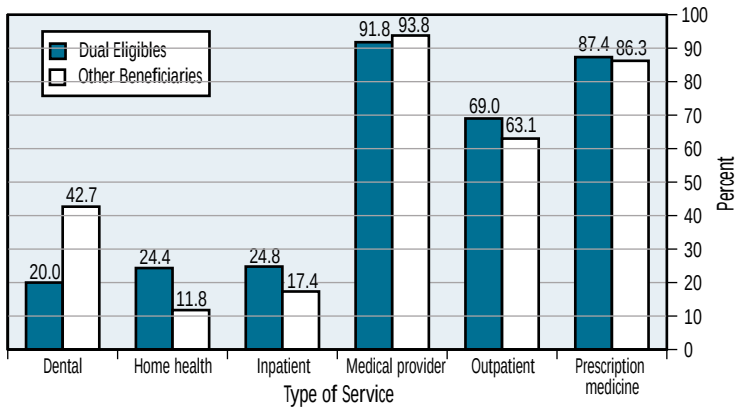


Figure 4-6 User Rates for Community-Only Residents, by Medicaid Status, 1995



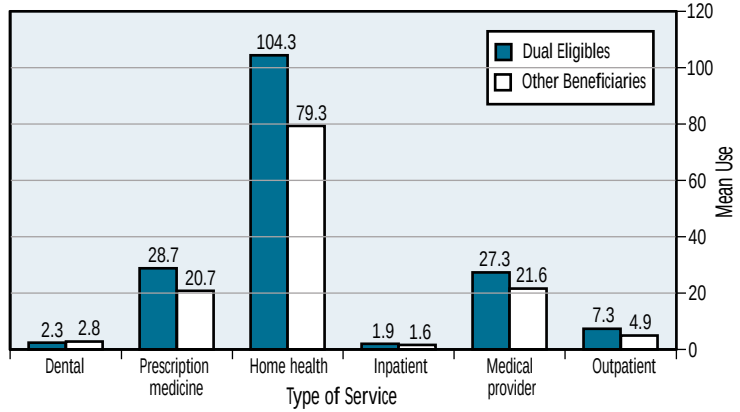
home expenditures out of pocket. On the other hand, the dual population who are nursing home residents also paid 44 to 72 percent of their income for health care.

Service Utilization

Dual eligibles tend to use more services than other Medicare beneficiaries. They have higher user rates and use services such as inpatient, outpatient, physician, medical supplies, prescription medicines, and hospice care more intensively (National Health Policy Forum,1997; Rowland and Lyons, 1998; Experton et al., 1997; Merrel et al., 1997). They are also more likely to use expensive post-acute and long-term care services. Dual eligibles accounted for 36 percent of Medicare's skilled nursing facility (SNF) and home health care services. Moreover, they represent a disproportionate share of the institutional population (almost 70 percent).

Figure 4-6 shows user rates for the dual population and other Medicare beneficiaries in 1995. The dual population was significantly more likely to use hospital and home health care services, but 50 percent less likely to use dental services. They also used more services than other beneficiaries. Figure 4-7 shows differences in the average level of service use by dual eligibles and nonduals residing in communities. The typical dual eligible used more of all types of services except dental care.

Figure 4-7 Average Use by Users Residing in Communities, by Medicaid Status, 1995



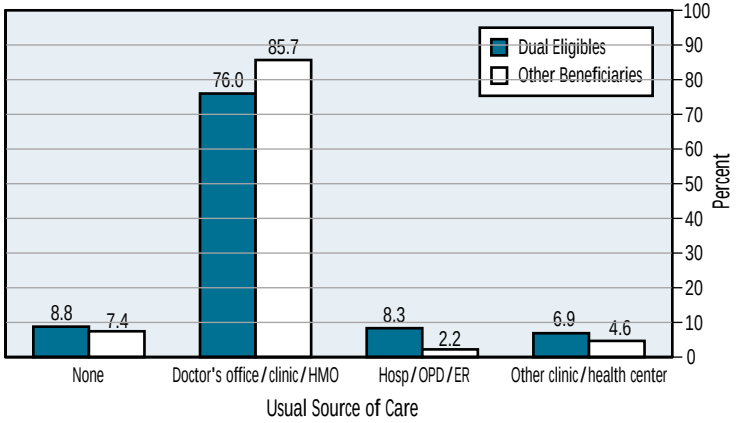
Research has found that several factors are related to high utilization of services among dual eligibles. More comprehensive supplemental health insurance coverage, such as the QMB program, is associated with significantly higher probability and intensity of use of health care (Parente and Evans, 1998). Poor health and more severe functional limitations also explain much of the cost differentials between dual eligibles and other Medicare beneficiaries (Liu, Long, and Aragon, 1998). Some researchers have argued that, in view of their high health care cost, more strict cost containment measures should be taken with this group (Experton et al., 1997). However, higher levels of utilization do not always translate into full access to health care, and there is evidence that the dual population still faces more access problems than other Medicare beneficiaries (Merrel et al., 1997; PPRC, 1996 and 1997; Rowland and Lyons, 1998).

Access To Care

Several approaches are used in analyzing access to care. One of them uses clinical measures of health care utilization to detect differences in access to particular services (Merrel et al., 1997; PPRC, 1996 and 1997). Another approach uses beneficiaries' responses to survey questions about sources of and satisfaction with health care, and barriers to receiving timely care. Based on these measures of access, the dual population has been found to have access problems to a certain extent. This population's access to care is affected by such issues as lack of continuity of care, limited administrative coordination between Medicare and Medicaid, institutional bias affecting service, and confusion with coverage and payment (Clark and Hulbert, 1998). Survey responses often indicate that the dual population is more likely to report delays and other barriers to obtaining proper health care.

The MCBS data further confirm these findings, and reveal different kinds of access problems masked by seemingly high utilization rates by the dual population. Figure 4-8 indicates that this group was less likely to maintain a usual relationship with a doctor. Dual eligibles are less likely to have a regular source of health care, and they are 4 times more likely to meet their health care needs by seeking temporary help at places such as emergency departments, hospitals, or outpatient departments. Even though the dual population indicates similar levels of satisfaction as other Medicare beneficiaries (Figure 4-9),[11] this population encountered significantly higher barriers to receiving timely care (Figure 4-10). They were twice as likely to report difficulties in obtaining health care, and much more likely to delay health care due to cost.

Figure 4-8 Distribution of Community-Only Residents, by Usual Source of Care and Medicaid Status, 1995



Clinically based measures also reveal that dual eligibles are more likely to exhibit patterns of care related to inadequate disease management, such as higher rates of emergency department visits within a year for the same health problem, more frequent hospital admissions, and significantly higher rates of institutional care (Merrel et al., 1997; PPRC, 1996 and 1997; Experton et al., 1997). The practice of substituting emergency medical services for regular health care is indicative of serious access problems. It raises issues about the lack of complete and quality disease management,

[11] Calculation of satisfaction rates excludes sample persons who reported "no experience" for the variable, e.g., "satisfaction with cost."

Figure 4-9 Proportion of Community-Only Residents Satisfied with their Care, by Medicaid Status, 1995

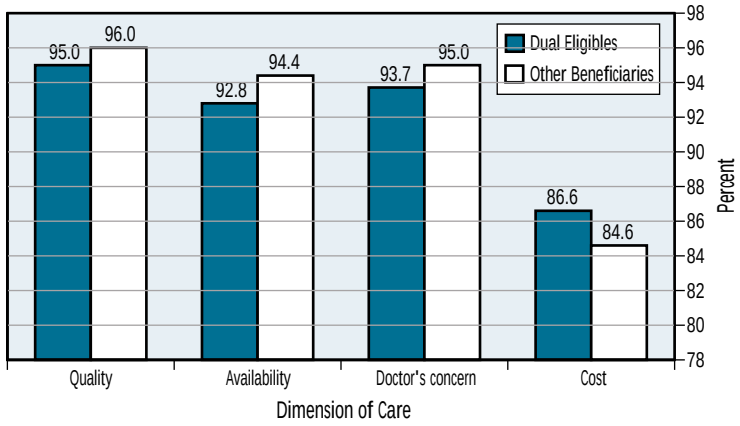
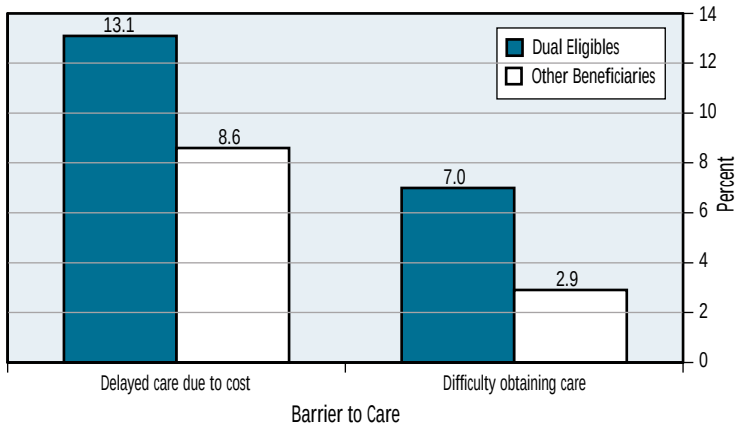


Figure 4-10 Proportion of Community-Only Residents Reporting Barriers to Care, by Medicaid Status, 1995



because emergency room patients are often treated to stabilize their conditions. Further medical measures to manage their health care problems are not provided, and complete health histories for patients are not kept on record.

Summary

Dual eligibles receive special attention from policy makers because their health care needs and expenditures are high relative to other beneficiaries. They are significantly more likely to require inpatient hospital and home health care, and they use more services of all types, on average, except dental care. In 1995, dual eligibles comprised 14.4 percent of the Medicare population, but they accounted for 38 percent of total expenditures by Medicare beneficiaries. Per capita spending by the dual population was more than double that of other beneficiaries, an average of $17,000 per person compared to $6,900 for the nondual population.

Dual eligibles lean heavily on public resources to finance their health care, with Medicare and Medicaid paying 44 percent and 35 percent of their health care costs. Medicare is the predominant public payer, covering 74 percent of all expenses if nursing home care is excluded. Medicaid spent more than one-third of its revenues on the dual population in 1995. Most of this spending was on nursing home care (85 percent of total Medicaid spending). Household spending constituted 12 percent of dual eligibles' total expenditures. Per capita out-of-pocket payments vary considerably by state and Census division, due to variation in the breadth and scope of Medicaid coverage and other geographic differences.

Issues related to dual eligibles' care did not receive much attention until recently. The bifurcated system involving two public programs and two payment systems often leads to inefficient practices. Providers often do not have clear incentives to be cost-efficient. Instead they can easily find motives to shift cost to other parties. The other consequence of the bifurcated system is inadequate management of health care problems due to poor or no coordination between Medicare and Medicaid. Beneficiaries are often unable to receive comprehensive care due to fragmentation of health services for dual eligibles. Both survey responses and clinical measures of

health care utilization point to access problems the dual population encountered, such as use of emergency rooms as a regular source of health care, and delays in seeking health care due to cost.